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**Methods of Assessment for Affected Family Members  
Jim Orford, Lorna Templeton, Richard Velleman and Alex Copello**

**ABSTRACT**

The chapter begins by making the point that a good assessment of family members' circumstances and needs is important if previous neglect of affected family members is to be reversed. The methods we have used in research studies are then described. They include a lengthy semi-structured interview covering seven topic areas, and standard questionnaires for assessing the impact of substance misuse on the family member and whole family, and the family member's symptoms of psychological and physical ill-health, and ways of coping. Also described are two methods for assessing social support available to a family member: drawing a social support network diagram; and a recently developed family member social support scale. The remainder of the chapter discusses the challenge of introducing standard family assessment and outcome monitoring into routine service practice, including the need for shorter versions of those assessments that have been used in research.

## **Why assessment for family members is important**

Our experience of working with services for alcohol and drug problems is that they are, for the most part, focused on the person whose substance misuse is causing difficulties; family members, by and large, are not the focus, and are involved in comparatively small numbers or on the periphery. Consistent with that focus, assessment methods are usually well developed and quite detailed regarding the substance misusing client – for example, in terms of the type and pattern of substance misuse, the person's circumstances, and treatment needs. The circumstances and needs of affected family members, on the other hand, are less likely to be assessed systematically or in detail. There is a vicious circle operating here. While family members remain on the edge of a service organisation's vision, then less effort is likely to be devoted to their assessment. While the circumstances and needs of family members are not fully assessed, less is known and appreciated about them and the peripheral position of family members is likely to be reinforced. Because in the course of our research we have spent so much time talking to affected family members it often comes as a surprise to us to realise how infrequently service providers – other than those few services specifically designed to help family members – spend dedicated time talking to family members, finding out about their concerns and understanding their perspectives and needs.

In this chapter we describe the semi-structured interview and standard questionnaire methods that we have developed in the course of our research with family members. These assessments have provided information which has led to the development of the SSCS model (described in Orford et al, 2010a, this volume) and have given data which has allowed for the model to be corroborated. Although we believe they cover

the core topics that might be included in a routine service assessment for family members, they were designed for research purposes and need adapting for routine use in service-providing organisations (in practice, services are also likely to require care plans, reviews, etc). The main adaptation required is simply to shorten the time they take. Our standard set of questionnaires usually takes 20-30 minutes to complete and sometimes it takes longer. The semi-structured interview, carried out fully, should take a minimum of an hour, and often it takes two to three hours.

The remainder of this chapter, therefore, starts by describing the full research versions of our assessments, their rationale, design, analysis and scoring. It then proceeds to describe how we are developing a realistic shorter package of assessments for routine use. The contents of the chapter are of relevance whenever family members are involved but are particularly relevant when a family intervention such as the 5-Step Method is being used.

## **The research assessments**

### *The semi-structure interview*

Table 1 lists the seven topic areas, and the sub-topics, that research interviewers are instructed to cover. The table only provides an overview; the detailed interview guide runs to 20 pages. To give an idea of the detail, Table 2 reproduces part of the interview guide that deals with just one of the topics – Section 3 on effects on the family member and others in the family. Although the guide is quite exhaustive, the objective is straightforward. It is to facilitate the interviewee in talking freely and at

length about the experience of being a close family member of a relative whose alcohol or other drug consumption has been a problem. In the spirit of good interview practice, the interview guide constantly reminds interviewers to do three things: (1) *follow leads* opened up by the family member; (2) *probe* thoroughly until the meaning of what is being said is full and clear; (3) *obtain concrete examples* of things that are said about family events and associated thoughts and feelings. For example, if a family member indicates that there has been personally upsetting behaviour directed towards her or him, this should be followed-up and specific examples obtained, and followed by careful questioning about any violence that may have occurred.

Table 1 about here

Although interviewers are free to tape-record interviews if they think it appropriate and helpful for preparing reports, the method we have used to record interviews does not depend on such recordings. Instead, interviewers are asked to take very detailed notes during the interview (including some verbatim quotes when they are particularly pertinent), and as soon as possible afterwards (preferably within 24 hours), to wordprocess or dictate a detailed report. Such reports may themselves be quite substantial documents, averaging about 4-5,000 words. There are both pragmatic and conceptual reasons for using such a method (see Orford et al, 2005a, Ch. 4). One of the most important pragmatic reasons for not relying on tape-recording is the time, cost and difficulty of making transcripts, or even of listening to recordings of long interviews. More fundamental still is our concept of the interviewer's task. A full recording is not necessary provided the interviewer-reporter can capture the main bulk of an interviewee's meaning (and some exact quotations from the interviewee are

usually helpful in doing that) in the report. Indeed a full transcription, with all the *ums* and *ahs*, repetitions and irrelevant asides, is often frustrating and unhelpful.

Table 2 about here

Using our method the interviewer becomes a kind of informant, in his or her own right, summarising what the interviewee has said and recounting this in a lengthy report. We believe that this method is a good one for obtaining in-depth material from people who have a lot to say about a complicated matter which is very personal and about which they feel keenly. It does rely, however, on the interviewer having been a more or less faithful sounding board for the interviewee, and providing a report which more or less accurately reflects what the participant said.

Our standard research procedure includes training for interviewers, covering both the interview itself and report writing. Some people are worried that careful note taking may interfere with developing a relationship and conducting a sensitive interview but that has not been our experience. With practice and experience most people master the technique well. Many practitioners are already very familiar with the process of careful interviewing, note taking and report writing. Some are reluctant to take notes during the interview and need practice to do that. The sounding board approach to interviewing is new to some practitioners who have been trained to be more directive in their questions or more interpretative in their reports. We ask interviewers to encourage interviewees to talk as freely as possible and to write reports which as faithfully as possible record the points that interviewees made. We do allow

interviewers to add any points of interpretation or commentary if they wish, but we insist that this be included as a separate addendum to the main report.

There is no need here to go into the details of how the data, in the form of post-interview reports, are analysed. There are now a number of well-established qualitative analysis techniques (Willig, 2008). Suffice it to say that the method we have used comes closest to a form of grounded theory approach (GTA) which aims to explore a phenomenon in depth and to produce a ‘dense’ descriptive model – for example a model of how family members cope, such as the one offered in Chapter 4 – and which views the result as representing important aspects of the reality of the lives of family members affected by and concerned about a close relative’s excessive drinking or drug taking (Glaser, 1992; Strauss and Corbin, 1998). We have used a number of GTA techniques, including open coding, later focused coding, constant comparison, analytic ‘seminars’, memo writing, selection of core categories and model building. At certain stages analysts worked in pairs or in larger ‘seminars’. This way of working together to study the interview reports and discuss their analysis can be a creative and exciting process. Preliminary conclusions can be taken back to research participants for their comments, although for practical reasons that is something that we have not done as often as we would have liked.

### *Three standard questionnaires*

The origins of each of the three questionnaires we have used regularly, and details of their psychometric performance (reliability and validity), can be found in an academic journal article (Orford, Templeton, Velleman and Copello, 2005b). Two of them

(FMI and CQ) are ones that we have developed ourselves. The third (SRT) is one developed by others which is freely available and which we chose as one that met our requirements. These three questionnaires measure three of the key elements in the SSCS model (Chapter 3) – Stress (FMI), Strain (SRT) and Coping (CQ).

Table 3 about here

#### Family member impact (FMI)

FMI is a 16-item questionnaire designed to assess the extent and type of harmful impact (stress) on the family member or on the family as a whole that a family member perceives the relative's drinking or drug-taking has been having recently (in the last 3 months). Response options for each item are: not at all, once or twice, sometimes, often – scored, respectively, 0, 1, 2, 3. The questionnaire can be scored as a whole to produce a total impact score, or to produce two sub-scale scores reflecting two different aspects of family impact: 1) *Worrying behaviour*; 2) *Active disturbance* (see Table 3 for example items).

#### Symptom rating test (SRT)

This is one of a number of questionnaires that are available for assessing the extent of mild to moderate physical and psychological ill-health in the general population (Kellner and Sheffield, 1973). Respondents are asked to indicate whether they have experienced each of 30 symptoms recently (in the last three months). This examines the 'strain' aspect of the SSCS model. Response options are never, sometimes, often



– scored 0, 1, 2. The SRT can be scored by summing all items to produce a total symptom score or, by calculating two sub-scales scores: 1) *Psychological symptoms*; 2) *Physical symptoms* (see Table 3 for example items).

### Coping questionnaire (CQ)

The aim of the CQ is to obtain family members' responses to a number of standard questions about the ways in which they have coped with their relatives' problem drinking or drug-taking recently (in the last 3 months) – the third component of the model. The CQ has also been adapted for family members of relatives with gambling problems (Krishnan and Orford, 2002). In all cases respondents are given four response options for each item: no, once or twice, sometimes, often – scored 0, 1, 2, 3. It can be scored by summing all items to produce a total coping score, or by calculating three sub-scale scores corresponding to the three main ways of coping which we have identified in our research (see Orford et al, 2010b, this volume): 1) standing up to the problem, or *Engaged coping*; 2) putting up with it, or *Tolerant-inactive coping*; 3) withdrawing and gaining independence, or *Withdrawal coping* (see Table 3 for example items). The questionnaire comes in two versions, one for use when the substance misusing relative is male, the other when the latter is female.

### Research evidence for the validity of the questionnaires

The three questionnaires have undergone a lengthy process of careful development. They also possess face validity as sets of questions that are very relevant to family members' experiences (see Orford et al, 2010b, this volume) and which should

therefore provide useful descriptive information. In addition there is now research evidence for their validity (Orford et al, 2005b), which includes the following:

- (i) In line with the expectation that family members are likely to be showing signs of strain, average SRT symptom scores of family members seeking help have now been found in several studies to be extremely high compared to control samples.
- (ii) SRT symptom scores have been found to be significantly correlated with FMI impact scores. That is consistent with the view that the strain experienced by family members is a consequence of the stressful impact of the substance problem.
- (iii) Independently of FMI impact scores, tolerant-inactive and engaged coping scores (particularly the former), but *not* withdrawal coping scores, have been found in a number of studies to correlate with SRT symptom scores. This supports the hypothesis that a family member's experience of strain can be affected by the way s/he copes.
- (iv) Partners have been found to do significantly more of both tolerant-inactive and withdrawal coping than parents.
- (v) Many of those results have been replicated outside England, in studies in Mexico (Orford et al, 2001) and Italy (Velleman et al, 2008).
- (vi) We have some evidence that culture makes a difference. For example support was found for the hypothesis that English Sikh wives would show a higher level of tolerant-inactive coping than White English wives. They also showed a higher level of engaged coping (Ahuja, Orford and Copello, 2003).

## *Assessing social support*

### (i) Drawing a social support network diagram

We have developed two formal ways of assessing the social support available to affected family members – the fourth component of the stress-strain-coping-support (SSCS) model. The first can be used as an integral part of Section 5 of the semi-structured interview. It involves drawing a social support network diagram as a convenient way to obtain and summarise in diagrammatic form a lot of information about the social support available to an affected family member (we use a very similar method with substance misusing relatives in order to map their social support – see Copello et al, 2010, this volume). The process of discussing and drawing a person's social network diagram in itself can be a very potent exercise. Not only can the resulting diagram summarise a great deal of information about a family member's family and social life, but it can also focus thinking on who might constitute additional sources of support for the family member which are not currently being used. An obvious way to begin is by drawing a symbol for each member of the household and each member of the wider family with whom the family member is in regular touch (symbols can be of any convenient type although circles or ovals are convenient, or circles for females and squares for males if the distinction between male and female is important). But the exercise is partly in the nature of a brainstorm about who is or might be available as support for the family member and who has been unsupportive (and therefore either to be avoided when it comes to looking for support or identified as someone who might be encouraged to be more supportive than they have been). It is therefore important to probe for individuals or groups of people,

or services or organisations, that have either been particularly supportive or unsupportive. Table 4 indicates some of the categories which should be asked about if they are not spontaneously mentioned.

Table 4 about here

(ii) The alcohol, drugs and the family social support scale (ADF SSS)

The second method for assessing social support is the most recent addition to the set of standard questionnaires. Item selection was based on a content analysis of the open-ended interview material from our earlier studies, followed by several stages of questionnaire development, leading to a 25-item questionnaire asking about support received in dealing with the relative's drinking or drug problem recently (in the previous three months). Response options for each item are: never, once or twice, sometimes, often – scored 0, 1, 2 and 3. All 25 items can be summed to produce a total ADF SSS score or sub-sets of items can be summed to produce three sub-scales scores: informal support (from friends or relations); failure of informal support (from friends or relations); and formal support (mostly from health or social care workers) (Toner, 2009; Toner and Velleman, 2010) (see Table 3 for example items).

**The challenge of incorporating family member assessments into routine service use**

The assessment methods described in this chapter were designed for use in research. However, we believe they address many of the key questions that are of interest to

any organisation providing services that include family members affected by relatives' addiction problems. We therefore recommend that, if time allows, such services should consider using these methods in full. We recognise, though, that incorporating such assessments into routine service practice represents a considerable challenge. This is something that has been forced on our attention during our work with service teams – the work described in Orford et al (2010c, this volume). Even when services are highly motivated to include affected family members, they are not always able to find the time to apply these research-based, but service-relevant, assessments.

The frame work of the in-depth interview described in Table 1 could be used or adapted for initial routine interview assessments. In common with any other forms of assessment, the interviewer could ensure that all the relevant sections are covered using the structure and the prompts suggested. The assessment framework therefore moves from contextual information about the family and the history and nature of the addiction problem to more specific effects, followed by coping, social support and health of the family member. Finally, issues about the future could be discussed. In this way all the components of the model can be assessed whilst providing an opportunity for the family member to tell the story, often an important issue earlier on in the development of a therapeutic alliance.

The set of four questionnaires amounts in total to 101 items. We are therefore currently engaged in the task of proposing and testing a shorter set of standard questions. A shorter version of the questionnaires, for routine use, might consist of a number of items in the region of 30. Using combined data from a number of our

research projects, candidate items will be chosen using two psychometric criteria: 1) items which, in a factor analysis of baseline data, load relatively highly on the factor corresponding to a sub-scale, and 2) items which show significant change in studies which followed-up family members after a period in which they had received an intervention. The proposed methods will require thorough testing in service settings; we are currently seeking service collaborators in order to carry out such tests.

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**Table 1: In-depth interview for family members: main topics and sub-topics**

1 *The Family*

Construct a family diagram  
Description of household accommodation and neighbourhood  
Description of the family's social and cultural background

2 *The history and nature of the relative's drinking or drug taking*

Nature of the relative's present drinking or drug taking and how it developed  
Type of drink or drug(s), method of administration, quantity, pattern, source, place  
Family member's own drinking and drug taking

3 *Effects on the family member and the whole family*

What life has been like at home for the family member, what problems the relative's drinking or drug taking has created, or in what ways the family member is concerned  
Have the lives of other members of the family been affected?  
Has the relative's drinking or drug taking had any positive effects?  
Have there been recent changes in effects on the family?

4 *How the family member has attempted to cope with the relative's drinking or drug taking*

Has the family member found her/himself reacting in certain ways?  
Which ways of reacting or coping has the family member found most useful, which least useful?  
Have changes occurred in the way the family member copes?

5 *Support for the family member in coping with the relative's drinking or drug taking*

Support the family member has, or has not received from each other member of the household  
From individual members of the wider family or from friends  
Support from the local neighbourhood or community  
Formal or informal support from expert sources of help including mutual help

6 *Health and well-being of the family member and other family members*

Family member's recent state of health and well-being, and how this has been affected by the relative's drinking or drug taking  
Health and well-being of other members of the family, and how affected by the relative's drinking or drug taking

## 7 *Overview and the future*

Is the relative's drinking or drug taking the real problem?

What does the family member think are the causes of the relative's drinking or drug taking?

Family member's hopes and realistic expectations, and what the family member feels s/he now needs to help cope with the problem

## **Table 2: Section 3 of the interview guide: effects on the family member and whole family**

### Purpose of this Section

The purpose is to obtain a description, from F's (the affected family member's) own perspective, of the effects of U's (the alcohol/drug user's) consumption of alcohol or drugs on F, on other members of the family, and on the family generally. By the end of this section it should be clear why F thinks that U's consumption has been a problem, and/or why F is worried about it. It should be possible to write an account of this from F's perspective including some of the exact phrases which F has used.

### Suggested procedure

- a) Ask F to describe in her/his own words WHAT LIFE HAS BEEN LIKE AT HOME for her/him, what it has been like living with U, what problems U's consumption of alcohol or drugs has created for F and other members of the family, or in what ways F is concerned about U's consumption.

In order to complete this section it may not be necessary to do more than ask this opening question and then to ask F to clarify and elaborate and to give examples. The following are specific topics which should be asked about if they are not spontaneously mentioned. For example, if nothing is spontaneously said about aggression or violence, F should be asked whether anything of this kind has occurred.

- b) Has F been concerned that U HAS NEGLECTED HIM/HERSELF, been apathetic, preoccupied, withdrawn, neglected work, school or other interests, etc?
- c) Has U's BEHAVIOUR towards F been UPSETTING towards F in any way (e.g. irritable, rude, demanding).
- d) Has F's RELATIONSHIP WITH U BEEN AFFECTED (e.g. by arguments, tension, poor communication, poor sexual relationship, reduction in trust, changed feelings of F towards U, separation, etc?).
- e) Has there been any VIOLENCE in the family (including threats, breaking things, etc?).
- f) Has U pressured F or other members of the family to LEND MONEY, or has STEALING occurred, or has F been suspicious about this?
- g) Has U's PARTICIPATION IN THE FAMILY been affected (e.g. U being missing from home, reduced role in family tasks, being left out of family occasions etc?).
- h) Have FAMILY ROUTINES AND RITUALS been affected (e.g. joint family meals, holidays, celebrations, times when the family plays or takes leisure together?).
- i) Has the FAMILY'S FINANCE OR STANDARD OF LIVING been affected (e.g. short of money, F has had to go out to work, F has had to give up work, etc?).
- j) Has F been upset by CONTACTS WITH PEOPLE OUTSIDE THE FAMILY that have occurred as a result of U's drinking or drug-taking (e.g.

embarrassing incidents with neighbours, contact with the police, contact with other drinkers or drug-takers, etc?).

k) Has F's SOCIAL LIFE been restricted?

The following question is important, and must be asked with respect to every member of the family living under the same roof with F and U (in both households if they live separately), as well as with respect to anyone else who is particularly important in the family (e.g. mother if F is sister and U is brother).

1) What does F think it has been like for OTHER MEMBERS OF THE FAMILY? Are there particular members of the family whose lives have been affected? Have the lives of children in the family been particularly affected?

If the situation is now improved in comparison with how it was, then the following questions should be asked.

How has life for F and the family changed since the situation IMPROVED?

**Table 3: Sample items from the Family Member Impact (FMI), Coping (C), Symptom Rating Test (SRT) and Social Support (SS) questionnaires**

<b>Sub-scale</b>	<b>Item</b>
Family member impact – worrying behaviour (FMI-WB)	<p>Recently (in the last 3 months):</p> <p>Have the family's finances been affected?</p> <p>Does your relative's drinking/drug use get in the way of your social life?</p> <p>Are you worried that your relative has neglected his/her appearance or self-care?</p>
Family member impact – active disturbance (FMI-AD)	<p>Does your relative pick quarrels with you?</p> <p>Has your relative sometimes threatened you?</p> <p>Has your relative upset family occasions?</p>
Coping – engaged (C-E)	<p>Recently (in the last 3 months) have you...</p> <p>Started an argument with him/her about his/her drinking/drug use?</p> <p>Got moody or emotional with her?</p> <p>Watched his/her every move or checked up on him/her or kept a close eye on him/her?</p> <p>Sat down together with him/her and talked frankly about what could be done about his/her drinking/drug use?</p> <p>Made it clear that you won't accept his/her reasons for drinking/taking drugs, or cover up for him/her?</p> <p>Made clear to him/her your expectations of what he/she should do to contribute to the family?</p>
Coping – tolerant accepting (C-TA)	<p>Put yourself out for him/her, for example by getting him/her to bed or by clearing up mess after him/her after he/she had been drinking/taking drugs?</p> <p>Given him/her money even when you thought it would be spent on drink/drugs?</p> <p>When things have happened as a result of his/her drinking, made excuses for him/her, covered up for him/her, or taken the blame yourself?</p>

Coping – withdrawal (CW)	<p>Pursued your own interests or looked for new interests or occupation for yourself, or got more involved in a political, church, sports or other organisation?</p> <p>Got on with your own things or acted as if he/she wasn't there?</p> <p>Sometimes put yourself first by looking after yourself or giving yourself treats?</p>
Symptoms – psychological (SRT-PSYCH)	<p>How frequently have you experienced each of the following symptoms recently (in the last 3 months)</p> <p>Worrying</p> <p>Irritable</p> <p>Thoughts that you cannot push out of your mind</p>
Symptoms – physical (SRT-PHYS)	<p>Parts of the body feel weak</p> <p>Cannot concentrate</p> <p>Awakening early and not being able to fall asleep again</p>
Social support – informal (SS-I)	<p>In the last 3 months:</p> <p>Friends/relations have listened to me when I have talked about my feelings</p> <p>Friends/relations have been there for me</p> <p>Friends/relations have talked to me about my relative and listened to what I have to say</p>
Social support – failure of informal (SS-FI)	<p>Friends/relations have said things about my relative that I do NOT agree with</p> <p>Friends/relations have said that my relative does NOT deserve help</p> <p>Friends/relations have said nasty things about my relative</p>
Social support – formal (SS-F)	<p>Health/social care workers have given me helpful information about problem drinking or drug taking</p> <p>Health/social care workers have made themselves available for me</p> <p>I have confided in my health/social care worker about my situation</p>

**Table 4: Drawing a social support network diagram: categories of people who should be asked about**

Work: any individuals or groups at work

Members of the family who have not been seen for a long time or who live far away

More distant members of the family such as cousins, nephews or nieces, in-laws, step-relations

Friends of the family, godparents

Neighbours or ex-neighbours

People who you are sorry you have lost touch with

People who have helped you in the past

People you share activities or interests with, such as sport, artistic, political

People who share religious worship or belief with you

People you often see in the course of your day-to-day activities, socialising, at the pub, etc

Any social or health services, or individuals who work there, who have been helpful